ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: July 30, 2018 Case Number: 19-11

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Alisa Reniker, DVM

Premise Name: 1st Pet Veterinary Centers

Premise Address: 1233 West Warner Road

City: Chandler State: AZ Zip Code: 85224

Telephone: (480) 732-0018

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Deborah Scarpelli, Ph.D.

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Home Telephone: [redacted] Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

RECEIVED
JUL 30 2018
BY:

C. **PATIENT INFORMATION (1):**

Name: Roxy Scarpelli

Breed/Species: Labrador Retriever

Age: 13 Sex: Female Color: Yellow

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. **VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

Alisa Reniker - 1st Pet Veterinary Centers, 1233 W. Warner Rd., Chandler, AZ 480-732-0018
Heather Hendricks - same information as above
Daniel B. Guastella - same information as above

Primary Vet for Roxy - Josh Finch - Baseline Animal Clinic, 220 E. Baseline Rd, Tempe, AZ 480-839-2824

E. **WITNESS INFORMATION:**

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Additional Emergency Clinic that Roxy was taken to when 1st Pet would not complete requested tests:
Kristi Burns, VCA Animal Referral and Emergency Center of Arizona, [redacted]

Husband - Richard McWilliam - [redacted]
Parent who accompanied to clinic - Dolores Scarpelli [redacted]

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: Deborah Scarpelli, Ph.D.

Date: July 28, 2018

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

Attached to these forms, please find additional letters written to 1st Pet Veterinary Centers in the hopes of resolving this matter. These letters clearly outline the chronology of events and resulting issues. It is my belief that negligence by 1st Pet Veterinary staff occurred while my pet, Roxy, was in their care which resulted in the amputation of her right front paw. Specifically, Dopamine was administered to Roxy's right front paw which leaked out of its IV catheter, causing necrosis of her paw tissue, requiring eventual amputation.

Specific issues of negligence include:
1. Failure to take an MRI as requested by owner when Roxy's paw showed significant swelling, bruising and oozing of bloody fluid requiring Roxy to be re-admitted to 1st Pet Veterinary centers on March 7, 2016.
2. Failure to take a culture of this fluid as requested by owner to determine any infection.
3. Failure to properly diagnose and treat the E. Coli infection Roxy contracted at 1st Pet Veterinary Centers (which was determined by VCA who conducted the culture.)

and most significantly,
4. Failure to contact poison control or administer phentolamine after the severe swelling began (even though clinical notes by Dr. Reniker indicated this should occur - see marked pages of medical notes provided). Several doctors indicated in their notes their concerns of her paw being "cool to the touch" and the significant swelling which caused Roxy to eventually stop walking, eating, and drinking.

Had Roxy been properly treated, the resulting amputation would not have been necessary and my dog would have resumed her normal, active lifestyle of walking two miles daily and swimming in our pool.

Instead, Roxy has required daily care in the administration of pain medications, bandaging of her front paw (stump) and the cessation of the active lifestyle she once enjoyed. In addition, it has been tremendously painful and emotional for me as her owner to watch her activity level decline and to administer her daily care. Her re-admittance to 1st Pet Veterinary Centers and ongoing care has also resulted in thousands of dollars of financial burden which would never have been the case if she had been properly cared for in the days following her initial bloat surgery. Lastly, I am concerned for future pet owners who may seek out care from 1st Pet Veterinary Centers as I do not believe an appropriate standard of care was practiced with Roxy, which resulted in changing her life forever to a much lower quality of life.

I am formally requesting the Board to order the licensee to reimburse the fees paid by myself as the pet owner due to the 2nd admittance to 1st Pet Veterinary Centers due to negligence of her paw and the resulting amputation per the new State of Arizona law that became effective 12/31/17. Thank you for your attention to this matter and please contact me if any further information is required to assist in this case.

ROWLEY CHAPMAN & BARNEY, LTD.
ATTORNEYS AT LAW

KEVIN J. CHAPMAN
KENNETH C. BARNEY
BRIAN D. STRONG
NATHANIEL H. WADSWORTH
JOSHUA R. BOYLE
PAMELA N. SANDBERG

January 13, 2017

1st Pet Veterinary Centers
1233 West Warner Road
Chandler, Arizona 85224

RE: Malpractice claim

To Whom It May Concern:

This firm represents Deborah Scarpelli, the owner of Roxy, an 11-year-old Labrador, who was treated at your clinic. This letter is sent to address Ms. Scarpelli's claims against you arising from the amputation of Roxy's paw in March 2016. Please direct all further correspondence in this matter to this firm.

Ms. Scarpelli took Roxy to your Mesa clinic at approximately 11:00 pm on March 1, 2016 because Roxy was experiencing extreme distress. You diagnosed Roxy with bloat and performed a three-hour surgery on her and kept her for five days. While Roxy was recovering from the surgery, your notes show that she experienced heart arrhythmias and swelling in her legs. On the evening of March 4, you began administering dopamine via Roxy's right front paw to assist with the arrhythmias. The records note that her right forelimb was painful, bruised and swollen to the touch. The next day, while the arrhythmias were improving, the right front limb continued to be swollen and painful and was cold to the touch. When Roxy was discharged on March 6, there were still concerns regarding her front right paw, which showed bruising and swelling.

The next day, Ms. Scarpelli saw that Roxy was still not putting pressure on the paw, which was discharging a bloody fluid. Roxy was also not eating, drinking or urinating. As a result, Ms. Scarpelli (with help from her parents) readmitted Roxy to your clinic on March 7 in order to determine whether Roxy had blood clots or an infection.

That night, Ms. Scarpelli requested that you perform an ultrasound or MRI to determine whether a blood clot was present in Roxy's leg, but your employees stated that the available equipment was not sensitive enough to detect a clot. Ms. Scarpelli also requested a culture of the fluid from Roxy's paw but was told that a culture would not reveal any new information because of the bacteria already present on Roxy's skin.

The next day, your clinic reversed its position and performed an ultrasound and echocardiogram, which came back negative. You began three antibiotics, water and laser

therapies, a Dextrose dressing to promote circulation, and began measuring the swelling in the paw. By March 10, the swelling in the paw finally began to decrease, and Roxy was discharged on March 11. Per your instructions, Ms. Scarpelli continued to administer three antibiotics to Roxy, the water therapy and Dextrose dressing, in addition to injections for pain relief every eight hours.

Notably, you did not perform a culture of the fluid from the front paw. We also note that on March 8, Dr. Alisa Reniker observed Roxy and made the following notation:

> Try to determine if dopamine infusion was given to RF leg – if yes, then consider Poison control call to determine if phentolamine infusion into the limb could still be helpful.

There is no evidence that poison control was ever contacted or that phentolamine was administered. However, it is plain from your notes that the IVC was placed in Roxy's "right medial saphenous vein for Dopamine/Dobutamine on 3/4/16."

On March 12, when Roxy's condition worsened, Ms. Scarpelli took Roxy to VCA for a CT scan and a culture of the paw discharge. Necrotic tissue was now building up on Roxy's paw, and my client was taking her to the veterinarian on a daily basis for bandaging and monitoring of the tissue. The results of the culture revealed that Roxy's paw was infected with E. coli.

After consulting again with your office, you recommended a full leg amputation. My client's veterinarian, Dr. Josh Finch, disagreed with doing a full leg amputation and ultimately amputated only Roxy's paw because of the necrotic tissue. The amputation marked the beginning of a painful recovery process for Roxy and Ms. Scarpelli. Based on the records provided by your office and the opinion of Dr. Finch, it is our belief that you were negligent in caring for Roxy following her bloat surgery. Had you properly administered the dopamine and/or caught your error in a timely manner, Roxy would still have her paw today.

With continuous daily treatments, several weeks of weekly visits and now regular monthly visits to the vet, Roxy is beginning to be able to walk short distances. Without her paw, she will never be as active as she once was. As you can understand, this entire ordeal has been extremely difficult for my client.

In order to better understand how this event has affected Ms. Scarpelli, you should know that Roxy is truly considered a part of the family. For years, Ms. Scarpelli and her husband tried to have children but were unsuccessful. In part, Roxy was able to take the place of children in their lives. Ms. Scarpelli raised Roxy from a puppy. Prior to losing her paw, Roxy was a very happy and active dog, regularly walking two miles each day with Ms. Scarpelli. In addition, Ms. Scarpelli, who is a Certified School Psychologist, trained Roxy to be a therapy dog and used Roxy in her work. To watch Roxy suffer was a tremendous ordeal for Ms. Scarpelli, so much so that she has been unable to raise her claims with you before now.

In addition to the emotional trauma, Ms. Scarpelli has incurred significant costs as a result of your negligence. To date, those costs include at least the following:

1st Pet	$7,236
VCA	$1,962
Dr. Finch	$1,595.51
Five days missed from work	$2,000
Medical supplies	$1,500
Boots for Roxy	$130
Ramp	$60
Total:	**$14,593**

These amounts do not include future medical costs for Roxy's care, which are expected to be another $5,000 over the next year. We estimate Ms. Scarpelli's total damages to be approximately **$20,000**.

In an effort to resolve this matter without the need for further legal recourse, Ms. Scarpelli is willing to accept payment of **$14,593** in exchange for a full release of her claims against you. Please contact me by no later than **Thursday, January 26, 2017**, to make arrangements for this payment. If you do not contact me, I will understand that you do not wish to work out a resolution, and I will advise Ms. Scarpelli accordingly. If it becomes necessary for Ms. Scarpelli to initiate a lawsuit, she will seek a judgment for all of her damages, in addition to interest, costs and attorneys' fees. Thank you for your prompt attention to this request, and I look forward to speaking with you soon to resolve this unfortunate matter.

Sincerely,

NHW/def
cc: Deborah Scarpelli

ZURICH

March 23, 2017

Nathanial Wadsworth
Rowley Chapman & Barney, Ltd.
SENT VIA E-MAIL: wadsworth@azlegal.com

Re: Our File Number: 9410552429 (9410551544)
Insured: Alisa Natalie Reniker, DVM
Claimant: Deborah Scarpelli
Date of Loss: March 1, 2016

Zurich American Insurance Company
Professional Programs

Administrative Offices
P.O. Box 968041
Schaumburg, IL
60196-8041

Telephone (800) 981-8912
Fax (866) 255-2962
http://www.zurichna.com

Dear Mr. Wadsworth:

This is to advise that Zurich American Insurance Company ("Zurich") has completed its investigation of the above captioned claim. We have discussed it with the Insured and reviewed the medical records. The ischemic necrosis was due to the severe illness, limb edema and possible emboli. Based on this investigation, Zurich has concluded that the Insured did not breach the standard of care and therefore, no malpractice was committed. Given this conclusion, we must respectfully deny liability and no payment will be made.

If you believe that there is any additional information that Zurich does not have in its possession, please feel free to submit such additional information for our review. If you wish to discuss this matter further, feel free to contact me at (847)413-3871.

Sincerely,
Zurich American Insurance Company

Alonzo Alcaraz
CLAIMS SPECIALIST
(847)413-3871.

ROWLEY CHAPMAN & BARNEY, LTD.

ATTORNEYS AT LAW

KEVIN J. CHAPMAN
KENNETH C. BARNEY
BRIAN D. STRONG
NATHANIEL H. WADSWORTH
JOSHUA R. BOYLE
NICOLE E. BERNABÉ

July 14, 2017

1st Pet Veterinary Centers
1233 West Warner Road
Chandler, Arizona 85224

RE: Malpractice claim

To Whom It May Concern:

As stated in our letter to you dated January 13, 2017, this firm represents Deborah Scarpelli with respect to the treatment of her dog, Roxy, at your clinic in March 2016. Following our initial letter, we were contacted by Zurich American Insurance Company, which represented itself to be your insurer. After multiple communications, Zurich informed us that it will not make any payment to Ms. Scarpelli. Having exhausted our efforts with Zurich, we are sending this second letter to you in a final attempt to resolve this matter before taking further legal action.

As a reminder, providers at your Mesa clinic operated for three hours on Roxy on March 1, 2016 following a diagnosis of bloat. Roxy remained at your clinic for several days, during which time you administered dopamine via Roxy's front paw. As described in more detail in our initial letter, that front paw became bruised and swollen and caused severe distress to Roxy, requiring her to be re-admitted to your clinic after her original discharge from the bloat surgery. After several more days and what we believe amounts to malpractice on your part, Roxy's paw was amputated because of necrosis of her paw tissue which we believe was caused by dopamine leaking out of her IV catheter. We have pictures showing the initial point of necrosis as the IV site and Roxy has scar tissue evidencing this fact. Roxy still has not fully healed, and Ms. Scarpelli must bandage Roxy's leg every day and keep the leg in a boot at all times.

Among other negligent acts, you failed to take an MRI of Roxy's paw when first requested, failed to take a culture of the liquid oozing from her paw, failed to properly diagnose and treat the E. Coli infection Roxy contracted at your clinic and failed to contact poison control or administer phentolamine after the swelling began (even though your own notes indicate that should have been done). We also have the opinion of Dr. Josh Finch that the paw could have been saved had you met the proper standard of care from the beginning.

This has been a tremendously painful ordeal for my client and her dog. We understand that mistakes happen, but my client does not accept your flat denial of liability and refusal to make amends. While my client prefers to reach an agreeable resolution to this matter, she is prepared to take further legal action, in addition to filing a complaint with the Veterinary Board. My client renews her request that you pay the amount of **$14,593** for the previously-detailed

damages. If you do not agree to pay this amount or otherwise propose a reasonable settlement by **Friday, July 21, 2017**, then my client will continue to pursue this matter through available legal means. Thank you for your prompt attention to this matter.

Sincerely,

Nathaniel H. Wadsworth

NHW/def
cc: Deborah Scarpelli

August 20, 2018

AZ State Veterinary Medical Examining Board
1740 W Adams St. Ste. 4600
Phoenix, AZ 85007

Re: Case 19-11

To the Investigative Division of the AZSVMEB:

I have received your July 31, 2018 correspondence regarding the complaint made against me by Dr. Deborah Scarpelli regarding the treatment of her dog, "Roxy." Enclosed, please find a copy of the medical record for Roxy, and a response to the January 13, 2017 letter received from Dr. Scarpelli's attorney, clarifying the inaccuracies in said letter. I am also providing the following timeline of important events in this case, response to the allegations against me.

This was a very complicated case, involving many doctors and technical staff from multiple hospitals. I am confident that everyone at 1st Pet Veterinary Centers, ARECA, and Baseline Animal Clinic were striving to provide the best care possible, to ensure Roxy recovered and had a good quality of life.

Timeline of important events in the Roxy Scarpelli case

3/2/2016 1 a.m.

Roxy presented to the emergency service for discomfort and was diagnosed with GDV (gastric dilatation volvulus) by Dr. Laura Goldman. Two IV (intravenous) cephalic catheters were placed. She was given emergency resuscitation treatment (IV fluids, pain medications, antibiotics), and was taken to surgery for stomach decompression, derotation and gastropexy. She received IV crystalloids and hetastarch (a colloid) during surgery. A gastrotomy was performed due to large, possible foreign material palpable in the stomach. Dog food and large pieces of rawhide and potato were removed.

Surgery, anesthesia and anesthetic recovery were unremarkable. She was placed on IV fluids, cerenia, famotidine, hydromorphone, KCl, unasyn, and later that day, transitioned to buprinex. She had some brief periods of hypotension and tachycardia that were treated with hetastarch boluses. Moderate anemia was noted.

3/3/2016

Overnight Roxy developed ventricular tachycardia (very common with post-op GDV surgeries) and was treated with a lidocaine bolus and then a CRI (constant rate infusion of lidocaine). Other treatments were continued. She seemed to have some abdominal discomfort, and so her analgesic was changed to a fentanyl CRI. Her potassium supplement (KCl) was increased and a metoclopramide CRI was started as well. The ventricular arrhythmia that morning was intermittent, so the lidocaine CRI was continued.

At 5:30 p.m., Dr. Hemberg called me to discuss some of Roxy's issues. I recommended more aggressive KCl (potassium) supplementation, as hypokalemia can exacerbate arrhythmias. Oxygenation and good perfusion (with optimal fluid therapy) as well as adequate analgesia can also be helpful in alleviating arrhythmias. As the myocardium of these pets is often hypoxic from the hypovolemic and distributive

shock they experience in GDV, many continue to show idioventricular rhythm or occasional VPC (ventricular premature contraction) despite anti-arrhythmic therapy for several days to weeks after the trauma. I explained that these abnormalities don't necessarily require treatment if perfusion parameters are normal. I also discussed implementing a magnesium CRI if hypokalemia resolved, but serious arrhythmia persisted. As the patient was very sedate, I recommended switching from the fentanyl to morphine, and adding an anti-emetic (ondansetron) due to the lidocaine and opioids contributing to nausea and inappetence.

Melena was seen that evening, and as patient was progressively anemic, Dr. Goldman recommended a packed red blood cell (pRBC) transfusion and the owner approved. The analgesic was changed to tramadol. Edema was noted in all 4 limbs.

3/4/2016

Overnight, Roxy received the first unit of DEA negative 1.1 pRBC without issue, but appeared to have a transfusion reaction to the second unit of pRBCs. The second transfusion was discontinued, fluid therapy and the other medications were continued.

That morning, Dr. Hemberg called me again for additional assistance due to the evidence of transfusion reaction overnight (tachypnea, hemoglobinuria), melena, the bloodwork abnormalities, the persistence and clinical symptoms from tachyarrhythmia and worsening edema.
I recommended performing PT, aPTT, and platelet count to assess coagulation and platelet numbers, and a 4 Dx (anaplasma, ehrlichia, heartworm, lyme) to rule out diseases that could cause low platelets. If Roxy was coagulopathic, I recommended considering a fresh frozen plasma transfusion. I recommended reassessment of total bilirubin, albumin, and creatinine once daily, and performing PCV/TS, blood glucose, electrolytes, blood gas, lactate every 3 to 6 hours. As the blood potassium levels were still not optimal, I recommended increasing supplementation, and discussed magnesium supplementation. In light of the patient's serious illness (GDV), surgery, transfusion reaction, demeanor, weakness, continued perfusion deficits, edema, and pigmenturia, I discussed systemic inflammatory response syndrome (SIRS) and recommended attempting to optimize perfusion with a low dose dopamine CRI (2.5 ug/kg/min) for renal blood flow and mild pressor support and dobutamine CRI (5 ug/kg/min) for inotropic support. I advised that these drugs can sometimes exacerbate an arrhythmia, therefore recommended careful patient monitoring with continuous telemetric ECG, hourly blood pressure, temperature, pulse, and respiration checks, close monitoring of fluid intake and losses (urine, diarrhea, vomiting). If this does not achieve end goals of improvement of perfusion and alleviation of arrhythmias, a sotalol trial might be in order. I suspected Roxy had systemic vasculitis contributing to third spacing of fluid (edema), causing the limb swelling and dependent edema seen on the doctors' examinations. I discussed hetastarch for oncotic support and improving intravascular volume. I also recommended as much physical therapy as Roxy would tolerate. Walking if she would -- passive range of motion exercises, massage, laser therapy as well.

I recommended adding Carafate, omeprazole, therapeutic barium, and misoprostal for more aggressive suspected GI ulcer treatment to address GI bleeding, and adding metronidazole with either ampicillin or unasyn to prevent bacterial translocation (movement of GI bacteria into the bloodstream). I also encouraged broad spectrum anti-emetic therapy and enteral feeding to promote GI healing. As some patients with SIRS have relative adrenal insufficiency, and this patient is suspected to have had a transfusion reaction, I recommended a physiologic dose of steroid once daily. (Please note that although Dr. Hemberg did not enter her exam into the computer until the evening, my consult and

implementation of recommendations occurred in the morning – see client communication 3/4/2016 11:49 a.m.)

At 10:08 a.m., after edema and pain had already been noted in the right front leg, the technician placed an 18 gauge, 2 inch catheter into the saphenous vein in the right HIND leg and started the dopamine/dobutamine CRI. This is clearly documented in the medical record and disproves Dr. Scarpelli's accusation of extravasation of dopamine leading to right front leg tissue injury and devitalization.

After implementation of these recommendations in the morning, Roxy's condition was noted by the evening and overnight technicians to have improved significantly – she was more bright and alert, her arrhythmia was very mild and intermittent, she was eating and drinking well, melena and diarrhea had diminished, her anemia had stabilized and potassium levels had normalized, she was wagging her tail, and she was walking around more, urinating outside.

3/5/2016

Dr. Goldman called the owners at 9:47 a.m. and advised them on the improvements Roxy had made. Her plan was to slowly wean from IV fluids, hetastarch, and pressor/inotrope support and transition to oral medications over the next 12 to 24 hours. The arrhythmias had resolved; the packed cell volume (anemia) was improving. The right front limb continued to be painful and physical therapy, hydrotherapy, massage and laser therapy were continued.

3/6/2016

Dr. Butler called and spoke to the owner at 8:30 a.m. and advised that Roxy had continued to improve. The EKG was normal and they had discontinued fluids, but she wanted to keep Roxy hospitalized through the day and ensure she continued to improve. She updated the client on the bill and estimate for the day.

Dr. Berko noted tachypnea on Roxy's examination findings, and buprinex was instituted for the front leg pain. Physical therapy and laser therapy were performed. Roxy was noted to be more responsive and less depressed that afternoon, but her leg was still painful. Her owners visited that evening and opted to take her home. She was discharged at 9:22 p.m.

3/7/2016

The owner called at 11:32 a.m. and advised that Roxy was eating and drinking well after discharge (the previous night), but not eating or drinking that morning. She said Roxy was not weight bearing on the right front leg and not moving around much. The owner had not given the famotidine or omeprazole. Owner said she would call back with an update.

Roxy was readmitted that evening at 7:45 p.m. for not using her back legs and not acting right. The owner reported that the right front leg seemed more painful and some oozing of blood tinged fluid was seen (resolved at time of visit). Dr. Hendricks noted swelling and pain in the right front leg. The antebrachium was warm to the touch, but the foot was cool. There was a 6 cm area of discolored skin. Roxy was ataxic in the hind limbs and not placing the right front leg.

Dr. Hendricks was concerned about a possible blood clot and recommended overnight hospitalization for pain management, IV antibiotics and fluid therapy, physical therapy, massage, laser therapy of the right front leg, and reassessment of bloodwork. She recommended consultation with the surgeon (Dr. Guastella) and Critical Care Specialist (myself) the next day. She discussed the possibility of limb amputation. She added Baytril (enrofloxacin) and placed Roxy on IV fluids, buprinex, and continued the medications previously prescribed.

3/8/2016

Overnight, Roxy's pain medication was changed to morphine, she received laser therapy, IV fluids, and IV antibiotics. She appeared much improved by the morning in terms of her discomfort. Dr. Guastella evaluated Roxy late morning, then I evaluated her when I got in to work in the afternoon. We also discussed the case with a board certified radiologist, Dr. Jim Hoskinson, and our Internist, Dr. Shery Babyak. The owners were visiting, and I went in to introduce myself and speak to them about Roxy and our collaboration with the other specialists. I had a very long talk with them, explaining all of the complications Roxy had experienced secondary to the GDV. Our concern for her right front leg at that time was that she had either experienced a thrombotic episode, a severe vasculitis or cellulitis (possibly sterile or septic). I also briefly explained necrotizing fasciitis, compartment syndrome from severe lymphedema, and reperfusion injury. I explained that we were trying to determine the best diagnostic approach and a definitive course of treatment. Dr. Hoskinson felt that the doppler ultrasound would be the best diagnostic imaging test to determine if there were any major arterial thrombi, and I recommended lactate assessment to compare perfusion to the left front limb. The ultrasound might not give us a definitive answer, but it would also evaluate for evidence of soft tissue abscessation and we could take ultrasound guided samples for bacterial culture or cytology, if indicated. Dr. Babyak recommended abdominal ultrasound to ensure there were no splenic infarcts contributing to the cardiac arrhythmias. The owners requested an echo, and I concurred that this was a good idea, but I was hopeful the arrhythmias were due to systemic inflammation and myocardial anoxia from the initial shock event.

At no time (from the time of re-entry until my conversation with the owner) did Dr. Scarpelli request an MRI. Had she been insistent, as she said she was, we could have easily referred them to the Veterinary Neurology Center. However, I don't believe Dr. Hoskinson (the radiologist consulting on the case) indicated MRI would have had any advantage to Doppler ultrasound or CT with contrast.

The owner agreed to the plan as outlined. The abdominal ultrasound was unremarkable, other than hypomotility of the stomach. There was no major arterial compromise seen to the right front limb and no areas of suspected fluid accumulation or abscess formation noted. There was no elevation of lactate in the right limb as compared to the left, indicating normal perfusion. The echo revealed some depression of myocardial contractility, but the measurements were not supportive of DCM. I recommended contacting the cardiologist, Dr. Church, regarding the necessity of antiarrhythmic therapy and inotropic support with pimobendan.

During my assessment on 3/8/16, I considered the possibility of dopamine extravasation and tissue irritation, since there did not seem to be an obvious arterial thrombus, pockets of infection, or any clear etiology for the right front limb abnormalities. I included it on my differential diagnosis list to be complete, but had not yet had the time to read through every entry of Roxy's previous medical record. However, it turns out that this was not an issue, as the infusion was never administered to the right front leg. This was why poison control was not contacted.

I made further recommendations including monitoring urine output closely (as Roxy had pigmenturia earlier in the week and kidney injury can occur from many of the complications associated with the GDV), changing the famotidine to ranitidine for pro-motility effects, changing her analgesic to morphine, continuing physical therapy, aggressive nutritional support and rehydration. Although blood clots of the major arteries supplying perfusion to the right front limb had been ruled out, thrombosis of small arterial dermal branches (to the specific areas of the affected skin) could not be ruled out completely, so I considered adding Plavix or baby aspirin if the cardiologist agreed.

3/9/2016

Roxy was stable, but had not improved. At this point, although the tissues in her right front limb were swollen and painful, there was not an obvious area that needed surgical debridement, so Dr. Guastella recommended a hypertonic sugar/dextrose bandage to try to alleviate some of the edema. Sugar bandages, if applied appropriately, also have antibacterial effects, and so this was discussed and approved by the owner as it would have dual benefits. Dr. Guastella also advised the owner he would administer a nerve block to ease the discomfort in the right front leg.

Dr. North, the emergency doctor, called the cardiologist and left a message requesting assistance.

When Dr. Guastella reassessed the leg later in the day and replaced the bandage, he felt there were mild improvements after the initial bandaging, and the brachial plexus block was providing analgesia as intended. The owner approved further treatment and bandage changes. As she was more comfortable and the morphine was causing some dysphoria, Roxy was switched to buprinex CRI.

3/10/2016

By the morning, the right front limb appeared less painful, had significantly less swelling, and had improved range of motion. The patient was willing to walk on the right front leg and was drinking. She was still having idioventricular rhythm with some intermittent tachycardia, but arterial blood pressure and perfusion parameters were not affected.

Dr. Church, the cardiologist, was advised of the case specifics and progression. Based on the information and the patient's current status, he did not advise adding additional medications, but did recommend reassessing the following week.

I spoke with Dr. Scarpelli and advised her of Dr. Church's advice and Roxy's progress. She expressed some concerns about finances, but was hopeful that her pet insurance would help to cover costs. She asked when Roxy would be able to come home. I advised that with the improvement of the limb, if we could keep her comfortable and if the owners felt they could perform bandage changes, we could attempt home care, but she would require frequent reassessment. Now that the edema was improved, there was an area of skin on the antebrachium that was questionable for survival. It appeared to be superficial, but it was difficult to tell with certainty at that time. I was also worried because the toes were still quite swollen and the nailbeds discolored, but the affected areas all had intact sensation and palpable pulses. We discussed surgical debridement and the possibility of amputation depending on the amount of tissue that sloughed. Dr. Scarpelli was reluctant to put Roxy under anesthesia unless absolutely necessary, and very resistant to the idea of amputation. I advised since the bandage changes appeared to be helping, we could continue these with frequent reassessment. The owners were set to

come in later and help perform the bandage change, and if they were comfortable with this and her condition, they could try home care. I would write up discharge orders and have supplies ready in case they wanted to take her home, otherwise, Roxy could stay in the hospital and we would perform further care.

I also spoke with Richard, while he was visiting Roxy, and explained all of this again, as well as my concerns for the viability of the tissue and the need for surgical assessment/debridement. I explained to Richard that if the tissue on the leg becomes necrotic, she could become systemically ill (sepsis). Ideally, we would proceed with surgery prior to this happening. It was a good sign that she was more comfortable and overall the appearance of the right front limb was improved.

3/11/2016

The owners elected to take Roxy home to attempt bandage changes and medication. The emergency doctor, Dr. Moentk, spoke to the owners prior to discharge, and emphasized that if Roxy's condition deteriorated or if they had any concerns, to return immediately. The technician again demonstrated hydrotherapy and bandage changes and Roxy was discharged. At the time of discharge, she was afebrile. The owner called that evening and advised that Roxy seemed to be doing very well at home.

3/14/2016

The owners missed their scheduled appointment and the surgery technician called and left a message.

3/15/2016

I called and spoke to Richard. He said that Roxy was doing very well. The paw was improved, and she was walking on her right front limb, eating and drinking. I missed Dr. Scarpelli's call, but she left a message that they had the sutures removed at the RDVM, and they had changed the bandage protocol, but were still keeping the right front leg wrapped. She advised that Roxy was eating better, getting stronger and moving around more.

3/16/2016

I left a message for Dr. Scarpelli and recommended reassessment by the surgeon.

3/17/2016

Dr. Scarpelli and Richard brought Roxy in for reassessment. When the bandage was removed, it was noted that the dextrose dressing had been discontinued, and the RDVM had the owners apply nitrofuracin to the wound. The owner confirmed that the bandage changes had been decreased to once daily and the dextrose solution was no longer being applied. In my opinion, the right front limb looked worse than when I had last seen it nearly a week before. There were now obvious areas of necrosis and the toes on the medial aspect of the paw were cool and did not have sensation, as they had previously. The leg also appeared more painful. There were areas on the antebrachium that appeared as an eschar, and some healthy granulation tissue was noted underneath.

Dr. Guastella and I had a long discussion with the owners in the treatment area, as we examined the wound with them and pointed out our findings and concerns. The owners were very reluctant to

anesthetize Roxy and extremely resistant to the idea of possible amputation. Dr. Guastella and I both tried to explain that at this time, there were obvious areas of dead tissue that needed to be removed. We explained the surgical debridement procedure (which was NOT an amputation of the limb, but removal of the superficial dead tissue), and advised that once Dr. Guastella was able to fully assess the wound, he would have a better idea of definitive treatment. I explained that I understood they were reluctant to amputate the leg due to quality of life issues, and discussed the possibilities of either skin grafting or wound vacuum if the necrosis was mainly superficial, and not affecting vital limb structures. I also addressed their concerns about anesthesia with a pre-operative assessment plan, and advised that I would perform anesthesia if they elected to move forward.

They declined diagnostic evaluation at that time, and wanted to continue with current treatment plan, following the bandage changes with their rDVM, consider their options, but take Roxy home for now. I emailed them their discharge instructions and an estimate for surgical wound debridement and assessment.

The next contact I had with Dr. Scarpelli was through her attoney's January 2017 letter, included in the paperwork.

Response to the specific allegations contained in Dr. Scarpelli's complaint:

"Specifically, Dopamine was administered to Roxy's right front paw which leaked out of it's IV catheter, causing necrosis of her paw tissue, requiring eventual amputation."

This statement is not factual. The right front limb was noted to be more edematous and painful prior to the initiation of the dopamine/dobutamine CRI. And, more importantly, the dopamine/dobutamine CRI was not administered in the right front limb at all. Roxy did have a dopamine and dobutamine CRI started the morning of 3/4/2016. As the previously placed intravenous catheters were in use, a new catheter was placed in the right medial saphenous vein. This is clearly documented in the medical record. (Technician Notes Jennifer Ripley 3/4/2016 10:08 a.m.)

"Failure to take an MRI as requested by owner when Roxy's paw showed significant swelling, bruising, and oozing of bloody fluid requiring Roxy to be readmitted to 1st Pet Veterinary Centers on March 7, 2016."

"Failure to take a culture of this fluid as requested by the owner to determine any infection."

Certainly, none of the doctors at 1st Pet 'refused' to perform these diagnostics. Dr. Hendricks readmitted the dog the evening of March 7th. There is no notation of the owner requesting an MRI or seeing bloody fluid to collect for culture (the owners had seen some fluid at home). Dr. Hendricks did start the dog on additional antibiotics, as cellulitis was a concern. Culturing fluid on the skin would likely grow environmental contaminants rather than a culpable bacteria. We do not have access to an MRI, and had the owner asked, she would have been advised of this fact, and would been referred to Veterinary Neurology Center. That night, Dr. Hendricks recommended hospitalization, IV fluids, cold laser, physical therapy, opioid analgesia, IV antibiotics (Enrofloxacin, to which most E coli are susceptible), and consultation with myself and the surgeon the following day -- the owners agreed.

The following day, the surgeon (Dr. Guastella), the internist (Dr. Babyak), the radiologist (Dr. Hoskinson), and I evaluated Roxy and discussed the best approach to her case. I can't speak directly to the discussions or interactions with the other 1st Pet doctors prior to the afternoon of 3/8/16 (as I was not present), but when I became involved with the case, ***all the decisions for care were made with the owners' input, consideration and consent***. We were partners in Roxy's care.

As a thrombotic event was considered the most likely cause of the right forelimb lameness, discoloration, and temperature differential, the radiologist felt that the best tool for evaluating the limb was doppler ultrasound. Based on his expert opinion, the doppler ultrasound was recommended and pursued. Due to Roxy's refractory arrhythmias, an echocardiogram and abdominal ultrasound were also approved by the owner, and Dr. Church, a cardiologist, was consulted.

Roxy was significantly more comfortable with the opioid analgesia given overnight and was weight-bearing when Dr. Guastella (and later I) examined her. She had arterial perfusion to the leg, as evidenced by normal lactate levels and doppler flow to the distal limb and paw. On 3/8/16, I had a comprehensive discussion with the owner in which the pros and cons of different treatment approaches were addressed, and the owners elected to try a nerve block and hypertonic bandages with frequent changes through the weekend, to see if the limb would continue to improve. The owners were very reluctant to put Roxy through additional anesthesia and surgery. Although amputation had been mentioned as an eventuality if the limb became non-viable or septic, bandage changes and surgical debridement with culture were felt to be reasonable alternatives while awaiting the tissue to declare final viability. Hypertonic bandages (with 50% dextrose) were chosen for their antibacterial and anti-edema effects. As the surface oozing was likely to be contaminated, we discussed a direct, deep tissue culture if staged surgical debridement was pursued.

"Failure to properly diagnose and treat the E Coli infection Roxy contracted at 1st Pet Veterinary Centers (which was determined by VCA who conducted the culture)."

Again, direct tissue culture was discussed with the owner as a more accurate method for diagnosing infection and would have been performed if the owner had elected to proceed with the debridement procedure recommended at the recheck visit. Roxy was placed on an IV antibiotic (enrofloxacin) to which E. coli is known to be susceptible.

Dr. Scarpelli was requested to bring Roxy back in for re-evaluation and continuing care on 3/14/16, but the owners did not show up for re-evaluation until 3/17/16, and declined to proceed with surgical debridement at that time.

"Failure to contact poison control or administer phentolamine after the severe swelling began (even though clinical notes by Dr. Reniker indicated that this should occur)."

At the time this recommendation was made (3/8/2016 7:46 p.m.), I did not realize that the dopamine had been administered in a hind leg, and not the right front leg. My notes state, "Consideration of extravasation of dopamine should be considered. I am not sure if this leg received the dopamine/dobutamine CRI." And then, "Try to determine if dopamine infusion was given to RF leg – if yes, then consider Poison control call to determine of phentolamine infusion into the limb could still be helpful." <u>As the dopamine/dobutamine were administered to the right hind limb, this is a non-issue, and a consultation with Poison control was not necessary.</u>

"Had Roxy been properly treated, the resulting amputation would not have been necessary..."

To be clear, during the time we cared for Roxy, amputation was discussed as a possible outcome, but it was never recommended as definitive treatment. Surgical debridement of devitalized tissue and exploration & culture of the wound, however, was discussed with the owners on several occasions, and strongly recommended 3/17/17. Throughout my interactions with them, the owners were understandably reluctant to put Roxy back under anesthesia due to all of her post-operative GDV complications. They were very hopeful that non-invasive treatments (the hydrotherapy and hypertonic bandages) would help them avoid further surgery.

I cannot comment on the 'necessity' of amputation, as the owner did not comply with 1st Pet medical recommendations after discharge on 3/11/2016. Dr. Scarpelli missed the recheck appointment on 3/14/2016. On 3/15/2016 I was told that Roxy was doing very well by both owners, and that they had decided to pursue further treatment with their veterinarian, who was no longer performing the hypertonic bandage changes multiple times daily, as we recommended.

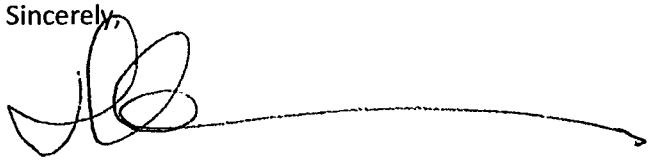
I am unsure of the timeline thereafter, i.e. when the culture at ARECA was performed or when or who recommended and performed the amputation. The last time we saw Roxy, on 3/17/16, the limb appeared more severely affected than at discharge on 3/11/2017. Surgical exploration and debridement of any devitalized tissue was again discussed and recommended, but the owners did not follow up after that time.

According to Dr. Scarpelli's lawyer's letter, dated 1/13/2017, Roxy was taken to ARECA 3/12/16 due to her worsening condition, and a CT and culture were performed. At some later time, the paw was amputated by their general practitioner.

I am truly sympathetic to Dr. Scarpelli. Roxy had an unexpected, life-threatening illness (GDV) with many complications post-operatively. This was a very stressful (and expensive) event for her family. However, the complications Roxy experienced did not result from negligence or malpractice. While under the care of 1st Pet 3/4/16 – 3/11/16, Roxy received the evaluation, advice, and care of 5 separate veterinary specialists (cardiologist, radiologist, internist, surgeon, and critical care specialist) and 5 very experienced emergency doctors, as well as a highly competent nursing staff. I cannot comment on events that transpired after her discharge or validate the necessity of the amputation.

Please do not hesitate to contact me if any further explanation is needed. I will be out of the country and unavailable from August 22 until September 5th. I will endeavor to respond quickly to any additional requests for information after my return.
If you need further input on this case, my attorney, Alex Cooper, is authorized to assist you. His phone number is 321.463.3332.

Sincerely,



Alisa Reniker, DVM Dipl. ACVECC

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Donald Noah, D.V.M. - Chair
Amrit Rai, D.V.M.
Adam Almaraz - ***Absent***
Christine Butkiewicz, D.V.M.
William Hamilton

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Victoria Whitmore, Executive Director
Michael Raine, Assistant Attorney General

RE: Case: 19-11
Complainant(s): Deborah Scarpelli
Respondent(s): Alisa Reniker, DVM (License: 3572)

SUMMARY:
Complaint Received at Board Office: 7/30/18
Committee Discussion: 11/6/18
Board IIR: 12/12/18

APPLICABLE STATUTES AND RULES:
Laws as Amended July 2014 (Salmon); Rules as Revised September 2013 (Yellow)

On March 1, 2016, "Roxy," a 13-year-old female Labrador Retriever was presented to 1st Pet Veterinary Center with gastric dilatation volvulus (GDV). The dog was hospitalized, surgery was performed and the dog recovered. During hospitalization, multiple post-surgical complications occurred including limb swelling due to suspected systemic vasculitis.

The right front limb continued to have pain and swelling and was cool to the touch; there were concerns of a possible blood clot and treatment was recommended. Possible limb amputation was also discussed with a surgeon.

The limb improved with hypertonic sugar/dextrose bandage treatment; however Respondent was still concerned for the viability of the tissue and the need for surgical assessment.

On March 23, 2016, due to necrosis, Dr. Finch at Baseline Animal Hospital performed a 5-digit toe amputation on the right front limb.

Complainant was noticed and appeared.
Respondent was noticed and appeared telephonically. Attorney, David Stoll, appeared.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Deborah Scarpelli, PhD*
- Respondent(s) narrative/medical record: *Alisa Reniker, DVM*
- Consulting veterinarian(s) narrative/medical record: *Baseline Animal Hospital; and VCA ARECA*

PROPOSED 'FINDINGS of FACT':

1. Complainant believes dopamine was administered to the dog's right from paw which had leaked out of its IV catheter, causing necrosis of her paw tissue, requiring eventual amputation.

2. Complainant's concerns specifically were:
   - Failure to take an MRI as requested by owner when the dog's paw showed significant swelling, bruising and oozing of bloody fluid requiring the dog to be re-admitted to 1st Pet Veterinary Centers on March 7, 2016;
   - Failure to take a culture of the fluid as requested by the owner to determine any infection;
   - Failure to properly diagnose and treat the E. Coli infection the dog contracted at 1st Pet Veterinary Centers.
   - Failure to contact poison control or administer phentolamine after the severe swelling began. Several doctors indicated in their notes their concerns of the dog's paw being cool to the touch and the significant swelling which caused the dog to eventually stop walking, eating and drinking.

3. On March 1, 2016, the dog was presented to 1st Pet Veterinary Center on emergency. Dr. Goldman, Respondent's associate diagnosed the dog with GDV and recommended surgery. Pre-surgical blood work was performed, two IV catheters were placed – one in each cephalic vein – and administered emergency resuscitation treatment. The dog was taken to surgery for stomach decompression, derotation and gastroplexy. A gastrotomy was also performed due to possible foreign material palpable in the stomach; dog food, large pieces of rawhide and a potato was removed.

4. The dog recovered and continued on IV fluids, antibiotics, pain management, stomach protectants and electrolytes. The dog had some brief periods of hypotension and tachycardia that were treated with hetastarch bolus. Moderate anemia was noted.

5. Overnight the dog developed tachycardia, was treated with lidocaine and other treatments were continued.

6. The dog remained hospitalized and medications were adjusted as the dog's condition warranted. The dog was becoming progressively anemic and a blood transfusion was performed. Edema was noted in all four limbs. The dog had a reaction to the second transfusion and was therefore discontinued; fluid therapy and other medications were continued. It was noted in the transfusion logs that the dog received the two transfusions on March 4th and the expiration dates were recorded as March 2nd.

7. On March 4, 2016, the dog had tachypnea and hemoglobinuria due to the transfusion reaction, melena, blood work abnormalities, persistent and clinical symptoms of tachyarrhythmia and worsening edema. Respondent recommended additional diagnostics to rule out other disease that could be causing low platelets. If needed, other treatments would be implemented. Blood values were monitored and treatments adjusted accordingly. The dog was monitored carefully and continuously due to the multiple post-op complications occurring. Respondent suspected that the dog's systemic vasculitis was contributing to third spacing of edema, causing the limb swelling and dependent edema (see on the doctors' examinations). Hetastarch for oncotic support and improving vascular volume was discussed. Respondent also recommended physical therapy, walking - passive range of motion exercises, massage and laser therapy.

8. An IV catheter was placed in the dog's right medial saphenous vein (right hind leg) and dopamine/dobutamine CRI was initiated. The dog's condition began to improve – she was bright, more alert, arrhythmia was mild and intermittent, and was eating and drinking well. The melena and diarrhea had diminished, the anemia had stabilized and potassium levels had normalized; she was wagging her tail, walking around and urinating outside.

9. On March 5, 2016, the dog was improving and the plan was to wean off IV fluids and transition to oral medications over the next 12 to 24 hours. The arrhythmias had resolved and anemia was improving. The dog's right front leg continued to be painful therefore physical therapy, hydrotherapy, massage and laser therapy was continued.

10. On March 6, 2016, the dog continued to improve although the right front leg continued to be painful. The dog was discharged that evening.

11. On March 7, 2016, the dog was readmitted due to not eating and drinking, non weight bearing on the right front leg, and not using her back legs. Respondent's associate, Dr. Hendricks, noted the swelling and pain in the right front leg and the foot was cool. There was a 6cm area of discolored skin. Dr. Hendricks was concerned about a possible blood clot and recommended overnight hospitalization for diagnostics and treatment. She further recommended consultation with the surgeon and Respondent, the critical care specialist. Dr. Hendricks discussed the possibility of limb amputation as well.

12. On March 8, 2016, Respondent, surgeon – Dr. Guastella, radiologist – Dr. Hoskinson, and internist – Dr. Babyak all discussed the dog's case. Respondent met with Complainant and discussed the collaboration with the other specialist and explained all the complications the dog had experienced secondary to the GDV. The concern for the right leg at that time was that the dog either experienced a thrombotic episode, a severe vasculitis or cellulitis. Respondent also explained that necrotizing fasciitis, compartment syndrome from severe lymphedema, and reperfusion injury. They were trying to determine the best diagnostic approach and definitive course of treatment. Dr. Hoskinson felt the Doppler ultrasound would be the best diagnostic imaging test to determine if there were any major arterial thrombi and recommended lactate assessment to compare perfusion to the left front limb. The ultrasound could also evaluate for evidence of soft tissue abscessation and they could take ultrasound guided samples for bacterial culture or cytology, if indicated. Dr. Babyak recommended an abdominal ultrasound to ensure there were no splenic infarcts contributing to the cardiac arrhythmias. Complainant

requested an echo, Respondent agreed as she felt that was a good idea. Complainant approved the plan.

13. The abdominal ultrasound was unremarkable. There was no major arterial compromise seen to the right front limb and no areas of suspected fluid accumulation or abscess formation noted. There was no elevation of lactate in the right limb as compared to the left, indicating normal perfusion. The echo revealed some abnormalities and Respondent recommended contacting the cardiologist.

14. On March 9, 2016, there was no improvement in the right limb swelling and pain. There were no obvious areas that needed surgical debridement therefore Dr. Guastella recommended a hypertonic sugar/dextrose bandage to try to alleviate some of the edema; these bandages also have antibacterial effects. He also advised Complainant that he would administer a nerve block to ease discomfort in the right front leg; Complainant approved the recommended treatment.

15. On March 10, 2016, the right front limb appeared less painful and had significantly less swelling and improved range of motion; the dog was willing to walk on the leg. Respondent spoke with Complainant relayed the dog could go home if she felt comfortable performing the bandage changes but the dog would require frequent assessment. Due to the improvement, there was an area of skin that was questionable on the antibrachium. The toes were still quite swollen and the nail beds discolored, but the affected areas all had intact sensation and palpable pulses. Respondent discussed with Complainant surgical debridement and the possibility of amputation depending on the amount of tissue that sloughed. Complainant was reluctant to anesthetize the dog unless absolutely necessary and very resistant to the idea of amputation.

16. On March 11, 2016, Complainant elected to take the dog home to attempt bandage changes and medication. Respondent's associate, Dr. Moentk, spoke with Complainant and technical staff demonstrated hydrotherapy and bandage changes; the dog was discharged.

17. On March 12, 2016, the dog was presented to VCA ARECA for evaluation. The dog was examined and it was noted that there was severe necrosis of skin on the right forelimb with swelling and purulent discharge. The dog was weak, not wanting to stand and had abnormal rhythm. Blood work revealed thrombocytopenia, anemia, and hypoalbunemia. A CT scan was performed as well as a culture of the discharge from the limb, and cytology of thoracic fluid.

18. CT scan showed cellulitis and soft tissue swelling of the right antebrachium and manus. Patent contrast enhancing vascular supply was seen throughout the limb. There was mild pneumonia of the left cranial lung lobe, mild pneumonia or interstitial infiltrate of the dorsal right caudal lung lobe with regional pleural effusion. Complainant declined hospitalization and the dog was discharged. Cytology and culture were pending.

19. On that day, the dog was also presented to Baseline Animal Hospital for a follow up exam. No notations in the medical record other than the dog's vitals.

20. On March 14, 2016, Complainant missed her scheduled appointment with Respondent.

21. The dog was presented to Baseline Animal Hospital for staple removal. Skin was starting to slough on the right front paw; the skin was split almost 360 degrees around paw. The limb was rebandaged and Dr. Finch instructed Complainant to apply scarlet oil.

22. On March 15, 2016, Respondent spoke to Complainant's partner, Richard, who relayed the dog's paw had improved and she was walking on her right front limb, eating and drinking. Complainant later reported in a message to Respondent that they had changed the bandage protocol, but were still keeping the leg wrapped.

23. On March 16, 2016, Respondent left a message for Complainant recommending a reassessment by the surgeon.

24. On this day, the dog was presented to Baseline Animal Hospital. It was noted that there was necrotic tissue sloughing off; there was healthy granulated tissue around where tendons on top of paw were. Scarlet oil was applied to the wound then mupricin to telfa pads and to necrotic skin areas. The leg was rebandaged. Complainant was instructed to continue changing out bandages daily applying scarlet oil and Vaseline to gauze squares and to wound prior to bandaging.

25. On March 17, 2016, the dog was presented to Respondent for reassessment. The bandage was removed and it was noted that the dextrose dressing had been discontinued and Dr. Finch had Complainant apply nitrofuracin to the wound. Complainant confirmed that the bandage changes had decreased to once daily and the dextrose solution was no longer being applied. The right front limb looked worse than the week prior. There were obvious areas of necrosis and the toes on the medial aspect of the paw were cold and did not have sensation as previous. The leg was painful and there were areas on the antebrachium that appeared as an eschar and some healthy granulation tissue was noted underneath.

26. Respondent and Dr. Guastella discussed their findings and concerns. Complainant did not want to anesthetize the dog and was extremely resistant to the idea of possible amputation. They tried to explain that there were obvious areas of dead tissue that needed debridement, which was not an amputation but removal of the superficial dead tissue. Due to the reluctancy to amputate Respondent discussed the possibility of either skin grafting or wound vacuum if the necrosis was mainly superficial. Complaint declined and wanted to continue with the current treatment plan.

27. This was the last contact Respondent had with Complainant.

28. Thoracic cytology = modified transudate.
Culture = E. Coli. Simplicef was recommended as treatment.

29. On March 23, 2016, the dog was presented to Dr. Finch for debridement. Dr. Finch performed all five digit toe amputation on the right front paw.

30. Respondent addressed Complainant's concerns in the complaint:

- The dog had an IV catheter placed in the right medial saphenous vein for administration of the dopamine/dobutamine. Poison control was not contacted to determine if

phentolamine infusion into the limb would be helpful since no dopamine/dobutamine was administered into the right front IV catheter;
- At no time did Complainant request an MRI. If she had they could have referred her to the appropriate premise. Dr. Hoskinson did not indicate that an MRI would have had any advantage to Doppler ultrasound or CT with contrast;
- The dog was placed on additional antibiotics, as cellulitis was a concern. IV enrofloxacin, which most E. Coli is susceptible to was started. Direct tissue culture was discussed with Complainant as a more accurate method for diagnosing infection and would have been performed if Complainant would have elected to proceed with the debridement procedure recommended at the recheck visit.

31. Respondent stated that Complainant did not comply with the medical recommendations after discharge on 3/11/16 and missed the recheck appointment on 3/14/16. On 3/15/16 Respondent was told that the dog was doing very well and they had decided to pursue further treatment with their regular veterinarian who was no longer performing the hypertonic bandage changes multiple times a day as recommended.

COMMITTEE DISCUSSION:

The Committee discussed that it was apparent that the dopamine injection was given in the right rear leg and not the right front leg. It is not clear what caused the sloughing of the skin and tissue in the dog's right front leg. The Committee felt the ultrasound that was performed was the better modality to determine possible circulatory issues in the dog's leg.

The Committee was pleased that the dog made it through GDV surgery especially with the cardiac issues that developed afterwards.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the *Veterinary Practice Act* occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 4 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.